

COMMENTARY

Who Gets Scarce Medical Resources during a COVID-19 Pandemic? Let's not beat about the Bush

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Abstract

Except for such rare situations where it might be determined absence of physician's imputability, physicians cannot 'save the most lives while respecting the legal rights of the patient' without violating the overarching principle 'every human life has equal value'. Arguing to the contrary is a conscious hypocritical attitude, or in other words, a fiction. Medical law and ethics long since carry with its various fictions. Furthermore, in a public health emergency such as the current COVID-19 crisis, medical law and ethics change and shift the focus from the patient-centered model towards the public health-centered model. Under these particular circumstances, this fiction becomes striking, and it can no longer be swept under the rug. As health emergencies can happen anywhere, anytime, the patient prioritization in circumstances of limited resources should be accepted. Medical law and ethics should back away from strict commitment to placing paramount emphasis on the value of human life. It is time for medical law and ethics to leave taboo-related hypocritical attitudes, and venture to make a historic compromise. To do so, three principles should be met: subsidiarity, proportionality, and consensus and social proof. (*Afr J Reprod Health 2020 (Special Edition); 24[2]: 32-40*).

Keywords: COVID-19 pandemic, scarce resources, withdrawal of ventilator, human life, conflict of duties, imputability, tragic dilemma

Résumé

À l'exception de ces rares situations où il pourrait être déterminé l'absence d'imputabilité du médecin, les médecins ne peuvent «sauver le plus de vies tout en respectant les droits légaux du patient» sans violer le principe fondamental «chaque vie humaine a une valeur égale». Prétendre le contraire est une attitude hypocrite consciente, ou en d'autres termes, une fiction. Le droit médical et l'éthique comportent depuis longtemps diverses fictions. En outre, dans une urgence de santé publique telle que la crise actuelle du COVID-19, le droit médical et l'éthique changent et déplacent l'attention du modèle centré sur le patient vers le modèle centré sur la santé publique. Dans ces circonstances particulières, cette fiction devient frappante, et elle ne peut plus être balayée sous le tapis. Comme les urgences sanitaires peuvent survenir n'importe où, n'importe quand, la priorisation des patients dans des circonstances de ressources limitées doit être acceptée. Le droit médical et l'éthique doivent renoncer à un engagement strict à mettre l'accent sur la valeur de la vie humaine. Il est temps que le droit médical et l'éthique abandonnent les attitudes hypocrites liées au tabou et se hasardent à faire un compromis historique. Pour ce faire, trois principes doivent être respectés: subsidiarité, proportionnalité, consensus et preuve sociale. (*Afr J Reprod Health 2020 (Special Edition); 24[2]: 32-40*).

Mots-clés: Pandémie COVID-19, ressources limitées, retrait du ventilateur, vie humaine, conflit de fonctions, imputabilité, dilemme tragique

Introduction

Medical law and ethics have long been ignoring that some instances constitute a paradoxical phenomenon. Miran Epstein uses the term fiction to describe these instances. In this paper, I borrow the term fiction. Epstein states that legal fiction is:

*'a proposition about the substance or procedure of the legal system purporting to be a principle or rule material to the determination of cases, which rests in whole, or in part, on a factual premise taken to be true by the courts of law, irrespective of whether it is true or false, and even though it might knowingly be false'*¹

Theorists have long been providing sophisticated arguments to continue turning a blind eye towards these fictions. This serves the purpose of observing certain taboo topics that have existed since the birth of bioethics. Below, I refer to some instances of such fictions. These fictions are related to the value placed on human life and autonomy.

The presumption that effective consent presupposes a certain degree of autonomy is a fiction, but rarely, if ever, reflects it. O'Neil puts it best in saying that the consideration that autonomy is a challenge to the physician's authority is an illusion. In fact, informed consent is leaving that authority untouched as the patient only accepts or refuses treatment proposed by physicians².

The presumption that withdrawal of life-sustaining treatment is morally different from active euthanasia (all other things being equal) is a fiction. The presumption that respect for refusal of life-saving treatment is morally very different from physician-assisted suicide is a fiction. The presumption that pressing a button to cease the ventilation can be regarded as an omission to act is a fiction. Several theories have been developed to justify this presumption. The multiplicity of theories indicates a difficulty in providing a satisfactory justification of an assumption, which in reality constitutes a paradoxical phenomenon³. Much of the same holds for the multiplicity of theories attempting to precisely determine when a physician has no further legal obligation to provide life-supporting treatment to a patient who is close to his or her inevitable death^{3,4}. Furthermore, the presumption that passive euthanasia of neonates and passive euthanasia of adults are equally accepted (or rejected), as well as that physicians are given equally broad discretion to decide about passive euthanasia regardless of whether the patient is neonate or adult, is a fiction⁵.

Several fictions that medical law and ethics have long carried (consciously) have been largely overlooked for decades. Nevertheless, under very particular circumstances, some fictions can become so striking that it is no longer possible for them to be swept under the rug. This is the case with the unprecedented coronavirus crisis, which

raises significant ethical concerns. Indeed, during these unprecedented times for global communities, the spread of the coronavirus outbreak around the globe has caused, among other things, a medical ethics crisis. Under these particular conditions, many health care ethics challenges are looming large on the background of yesterday's debate. One of these challenges is related to an important fiction of medical ethics. This is the presumption that patient prioritization in circumstances of limited resources during health emergency is consistent with placing paramount emphasis on the value of human life and the principle 'every human life has equal value and worth is the same'. There might have been several reasons for this. While before the COVID-19 pandemic death was regarded as an isolated phenomenon in which none wanted to become involved, the current pandemic is a rapidly evolving situation that threatens everyone's life, and daily death tolls have become unusually important to everyone. As the vast majority of coronavirus deaths are happening in hospitals (especially in the intensive care unit), ethical dilemmas surrounding intensive care unit admission and discharge have gained focus and have been brought to the fore. Besides, since the conflict between two equally strong duties extends beyond the positive law, many legal theorists have been reluctant to reflect on it.

Moreover, it should be highlighted that medical law and ethics have long been turning a blind eye to the above-mentioned fiction, with good reason. It is of crucial importance that during the Second World War, the assumption 'there is life unworthy of living' has been suggested by theorists of National Socialism and constituted the fundament of the medical ethics of the Nazis⁶. After the horror of the Second World War, respect for human life and the fundamental rights of individuals have been turned into a taboo. More than 40 years on from the birth of bioethics and more than 70 years since the end of the Second World War, both medical ethics and legal theory have been strictly committed to taboos. For instance, taboos are mirrored in 'valuing all lives the same', 'placing the highest value on human life', or 'placing paramount value to autonomy'. In

a similar vein, international legislations and declarations (i.e., article 2 of the European Convention on Human Rights and article 5 of the European Convention of Human Rights and Bioethics-Convention of Oviedo), as well as national Constitutes (i.e., article 2§1 of the Greek Constitution in combination with the article 5§1 of the Greek Constitution), put the highest value on human life and paramount emphasis on autonomy, respectively.

The academic literature on the value of human life, is growing. Nevertheless, few have addressed whether it can be claimed that deeming patient prioritization in circumstances of limited resources during emergency medical care to be consistent with placing paramount emphasis on the value of human life is a paradox (fiction). In this paper, I advance the debate further by examining the arguments put forward to justify the physician's choice in case of patient's prioritization against a background of the scarcity of resources while placing paramount emphasis on human life. Then, I provide a discussion and a compromise solution.

Deciding 'who gets a ventilator'

The intensive care unit physician who has multiple patients presenting at the same time, while having equal chances to survive, does not face legal risks over their choices. Note, however, that in a clinical routine, it seems to be so rare that it is possible to exempt the physician from liability on this basis. In clinical practice, it is so rare to have multiple patients presenting at the same time while having *exactly* equal chances to survive in the intensive care unit. In my opinion, much of the same holds for the case of a physician who has multiple patients presenting at the same time while having *not* equal chances to survive in the intensive care unit, *if and only if*, due to conditions of emergency the physician is forced to decide and act spontaneously and indiscriminately (having taken a blind guess). If this is the case (of actual or perceived equally strong medical duties), there is a conflict between two duties that are equally strong not only in reality but also in physicians' perception. Law and legal theory, as well as moral

philosophy, cannot provide a solution and, hence, whatever the physician chooses cannot be considered finally wrong⁷⁻¹⁰. The physician just follows in fate's steps¹⁰. Besides, the impossible is no legal *obligation (impossibilium nulla obligatio est)*^{7,8}. Also, the physician might be regarded as excusable (non-imputable) provided that, under particular circumstances, the physician could not act otherwise¹¹. Whatever choice the physician makes, it will be the wrong one. The physician might be considered non-imputable for two reasons. First, because he or she is under great psychic pressure to choose between two equally strong duties. Second, because neither legal theory nor moral philosophy can give a satisfactory solution to that dilemma. Physicians do not face legal risks over their choices because they must confront an intrinsically inextricable dilemma.

This is a tragic dilemma. From the viewpoint of moral philosophy, Kent offers an interesting justification of the wrongness of the act of (whatever) choice between 'two horrific or repugnant options'¹². The author provides 'a virtue ethical account of right and wrong action whereby an act is right (or wrong) if and only if it is what a virtuous (or vicious) agent would characteristically do'¹². Then, she writes that 'since the action in a tragic dilemma is one that is characteristic of the vicious agent, the action is a genuinely wrong action'¹², and adds: 'One concern with such an approach is that wrongdoing diminishes goodness, and so one's goodness is subject to luck'¹².

However, major legal and moral concerns are raised in case of multiple patients presenting at the same time while having *not* equal chances to survive in the intensive care unit. For instance, this is the case for a physician who has to choose between a young patient without pre-existing medical conditions (with a significant chance of survival) and a much older patient with grave pre-existing medical conditions (with a very remote chance of survival).

Importantly, it is argued in the literature (as mentioned below) that there might not be wrongdoing if the physician chose in favor of the young patient. However, claiming that the choice of the patient who will 'get the ventilator' might

be based on criteria related to patient's traits or conditions while fully respecting human life as the highest (and absolute) value, is a hypocritical attitude that masquerades as a legally justified consideration.

Very recently writing about the devastating effects of scarce resources allocation in the recent coronavirus crisis in Italy, Manelli states: 'It seems fair that equals deserve equal treatments, but each of us has very different characteristics, and these cannot be ignored'¹³. Then she adds: 'When patients present the same medical condition, factors such as age, comorbidity, gender and severity of the disease have an impact on the specific protocols that physicians follow. Since equals should be treated equally, it is unequal to treat unequals equally'¹³. This is correct. However, this is not the case when it comes to decisions about who gets the scarce resources in the life-threatening pandemic of coronavirus. Valuing all lives the same and placing the highest value on human life while justifying the decision who gets treatment based on the assumption that the unequal should not be treated equally is a paradox. Of course, each of the patients has different characteristics that might formulate the treatment protocols that physicians follow; they are not equal in this sense. However, they do have an equally strong need to stay alive and, hence, the physicians' duty of care is equally strong towards all the patients in need. In this sense, they are equal and should be equally provided with the necessary resources. This is not an easy task when resources are scarce.

Nevertheless, it has been argued that in the context of intensive care units, it is often necessary to decide who gets treated first and who is left out. Thus, physicians can remain unpunished based on the absence of imputability, even if they have treated patients based on factors such as age, pre-existing conditions, and whether they have a family. This violates the overarching principle of medical ethics where the paramount emphasis should be placed on the value of human life. The deontological rejection of that principle might go about in the guise of the utilitarian (consequentialist) claim of pursuing the least

possible harm to as many people as possible. However, it could be argued that a physician who has treated patients based on factors such as age, life expectancy, or pre-existing medical conditions might remain unpunished because of the absence of imputability.

However, in my opinion, only in rare and exceptional cases it might be claimed that a perpetrator (namely, the physician in question) was criminally imputable. Otherwise, such a justification constitutes a hypocritical attitude. Below I provide some further explanation.

I suggest that a further understanding of the concept of penal imputability is needed before determining the absence of penal imputability in the clinical context. When we attempt an imputability-based solution, we shift the focus from the action towards the mind of the actor (physician). Except when one cannot act otherwise than they do, the absence of penal imputability is understood as an incapacity to appreciate the criminal wrongdoing of an act or omission because of intense psychological or moral pressure. For example, if a physician experienced particular conditions that led him or her into deadlock. Thus, the physician cannot choose between criminal wrongdoing and 'right-doing', and act accordingly. In hindsight, the physician could not act otherwise. Therefore, responsibility cannot be attributed to the physician, and finally, he or she remains excusable. In other words, the capacity of the brain's ability to perform basic functions that underlie the choice between criminal wrongdoing and doing the right is seriously affected. That is to say that the absence of imputability might be regarded as (quasi or not) severely limited brain-bandwidth at least in one domain. In the context of healthcare provision, this might vary due to various and distinct factors, such as excessive fatigue, state of emotional arousal, high level of moral distress, panic, or high time pressure. Unexpected emergencies are usually responsible for these situations.

These situations cannot be considered part of the routine. In the case of an ongoing emergency (as is the case with coronavirus pandemic), these situations might appear much

more often. If the absence of imputability is (arguably) regarded as a situation of limited brain-bandwidth, it would be rare to be confirmed in the practice and procedure of the courts. When it comes to cases of medical liability, where the circumstances in which the acts or omissions took place were ‘emergency medical conditions’, the court might have a hard time to determine as to whether the accused physician was, in reality, incapable of making a choice between wrongdoing and doing the right, or decided ‘who gets the ventilator’ against a background of the scarcity of resources in intensive care following a pre-existing priority list. Namely, the court might have difficulty determining whether, a storm occurred in the physician’s mind or if the physician acted as if he or she was working under normal conditions. Hence, the rejection of a primary touchstone in bioethics claiming that highest value should be placed on human life and human lives should be valued the same might, in all likelihood, masquerade as the absence of penal imputability.

Deciding whether to withdraw ventilator support

Consider the case of a patient on a ventilator with practically no chance of survival while another patient is presenting with a significant chance of survival. When classifying a patient at the bottom of the priority list based on factors, such as his or her traits (e.g., medical conditions, age, life expectancy, marital status), you facilitate a balance between his or her life and the life of (at least) a second patient who, *unfortunately* for the first patient, was taken to the hospital at the same time or later where the first patient was on a ventilator. The medical treatment of the patient would remain intact if he or she were the only patient in the hospital setting. If every human life were regarded as having equal value, the treatment trajectory of the first patient would not be affected by factors that were *external* to the patient or his or her hospital setting. Liddell et al. state: ‘There is a range of triage policies, created by various organizations, that set out detailed protocols for prioritizing scarce resources in intensive care, including ventilators’¹⁴. Besides, they write:

‘Most of this guidance is infused with the ethical principle ‘save the most lives’¹⁴. In the authors’ view, it should be formulated as follows: ‘save the most lives *while respecting the legal rights of the patient*’¹⁴. Moreover, they state that ‘withdrawal of ventilation before a round of treatment has been completed should *not be solely based on relative prioritization of patients*’¹⁴. The authors put it best in saying ‘...doctors take substantial legal risks if they follow advice published by unauthoritative sources ...set out in policies that have not been made publicly available’¹⁴. The existence of such tolerance towards physicians’ discretion as to whether or not to withdraw ventilator support based on prioritization of patients most likely to survive over those with remote chances (based on medical and biological characteristics that profoundly affect the outcome of care) is a hypocritical attitude in stark contrast with the principles ‘every human life has equal value’ and ‘human life is the highest value’.

From the above consideration (‘save the most lives *while respecting the legal rights of the patient*’), with a patient on a ventilator with practically no chance of survival, and another patient is presenting with a significant chance of survival, it is not difficult to decide the withdrawal of the former from the ventilator for the sake of the latter. Various suggestions have been offered in the literature to justify the withdrawal. However, in my opinion, none of these are morally and legally sound.

In Greek theory, there is the suggestion that the physician who practices the withdrawal does not make a life-or-death decision. Namely, he or she is not ‘playing God’. The physician simply follows in fate’s steps⁸. It is for this reason that the physician’s act is not criminally wrong⁸. When death is imminent, it is argued that it is about the same death, whether practicing withdrawal or not. It is not about a substantially different death¹⁰. This suggestion stems from the German legal theory. Another opinion invokes the application of the situation of necessity in criminal law by analogy and, therefore, argues that the harm caused to the patient with no chance of survival is no more than an insignificant harm¹⁵. These

suggestions argue for abolishing the wrongness of the act of withdrawal of a ventilator from the patient with no survival chances. A Greek court adopted a similar approach¹⁶. Obviously, under the above-mentioned suggestions, when it comes to infaust prognosis and death is imminent, there might be a hidden rejection of the assumptions ‘every human life has equal value’ and ‘human life is a value of the highest degree’.

A more sound justification seems to be arguing for the physician’s absence of imputability^{7,8,11,17}. This justification shifts the focus from the wrongness of an act or omission (namely, the justification of the act or omission) towards the imputability of the person who acts or omits (namely, the possibility of excusing the physician). Determining the absence of imputability would not subject the physician to criminal liability. However, as it is anticipated above, this is likely to apply only in rare situations. In the vast majority of cases, the rejection of the principle of the unrated protection of human life might go about in the disguise of the absence of imputability (thus becoming tolerated).

Let us not beat about the bush: From hypocrisy to historical compromise

The contemporary literature highlights the need for developing prioritization guidelines and the paradox that public health-centered medicine takes precedence over the traditionally emphasized patient-centered medicine. I indicate some sources from the very recent literature (March/April 2020). Emmanuel et al. write: ‘In the context of a pandemic, the value of maximizing benefits is most important’¹⁸. Furthermore, the authors state: ‘Prioritization guidelines should differ by intervention and should respond to changing scientific evidence’¹⁸. ‘Saving more lives and more years of life is a consensus value across expert reports’¹⁸. They consider that it might be justifiable to give priority to maximizing the number of patients that survive treatment with a reasonable life expectancy and to regard maximizing improvements in length of life as a subordinate aim¹⁸. The authors believe that this is consistent both with utilitarian and deontological

ethical perspectives¹⁸. Note, however, that many years before the COVID-19 crisis, the study of Fortes and Pereira with public health professionals and students showed ‘a clear tendency to justify the choices that were made guided by utilitarian ethics’¹⁹. The authors found that ‘the choices prioritized children, young individuals, women and married women, with decision-making invoking the ethical principles of vulnerability, social utility and equity’¹⁹. In the current COVID-19 crisis, Berlinger *et al.* write that:

*‘duties to promote moral equality of persons and equity (fairness relative to need) in the distribution of risks and benefits in society. These duties generate subsidiary duties to promote public safety, protect community health, and fairly allocate limited resources, among other activities. These duties and their ramifications are the primary focus of public health ethics’*²⁰.

*‘Public health emergencies require clinicians ...to prioritize the community above the individual in fairly allocating scarce resources. The shift from patient-centered practice supported by clinical ethics to patient care guided by public health ethics creates great tension for clinicians’*²⁰.

De Panfilis *et al.* similarly state:

*‘In a public health emergency such as the current COVID-19 crisis, an ethically sound framework has to balance the patient-centered duty of care—the focus of clinical ethics under normal conditions—with public-focused duties to promote equality of persons and equity in the distribution of risks and benefits in society—the focus of public health ethics’*²¹.

The quotations mentioned above indicate that the COVID-19 pandemic crisis is an extraordinary (exceptional) situation that profoundly affects fundamental principles and perceptions of medical law and ethics. Deeming patient prioritization in circumstances of limited resources during emergency medical care to be consistent with placing paramount emphasis on the value of human life is a fiction. In these particular conditions, this fiction becomes striking, and it can

no longer be swept under the carpet. As health emergencies can happen anywhere, and at any time, the patient prioritization in circumstances of limited resources should be accepted. Medical law and ethics should prominently backtrack from strict commitment to placing paramount emphasis on the value of human life. Now it is time for medical law and ethics to grow up. More precisely, it is time for medical law and ethics to leave taboos and taboo-related hypocritical attitudes, and to make historic compromise.

However, three conditions should be met in order for the patient prioritization in circumstances of limited resources (namely, deviation from placing paramount weight on human life) to be accepted. First, the principle of subsidiarity should be met. Subsidiarity provides a moral and legal obligation for those involved in patient prioritization to do their utmost to meet the principle of mutuality. That is to say that the deviation above might be morally and legally accepted *if and only if* all the stakeholders involved in the dilemma above have done their utmost to circumvent or eliminate it before the occurrence of a health emergency. Second, the principle of proportionality should be met. Third, the principle of consensus and social proof should be met. That is to say that the degree of the deviation above should receive wide, fair, and democratic acceptance by the public.

According to the ‘mutuality principle’ (devised by DeMarco), hard-to-solve conflicts between fundamental bioethical principles should be addressed by creating ‘alternative options and circumstances’, under which a true compromise can be achieved, or the conflict can be eliminated, circumvented, or solved coherently by enhancing all the principles that get into conflict with each other²². Thus, a fair compromise can be reached. In the case of a health crisis, when prioritizing patients against a background of scarce medical resources, it is most likely that the principles of beneficence, nonmaleficence, and justice will inevitably conflict with each other. Therefore, and following the principle of mutuality, much before the outbreak of the crisis, stakeholders such as intensive care unit practitioners, hospital

administrators, governments, and policymakers must work (under the direct supervision of the state) on minimizing the need for allocation of scarce resources.

In that regard, it should be noted that developing plans for the allocation of scarce resources in case of future health emergencies is not an easy task. As the threat of major public health emergencies spreads across the world, and the demand for medical (i.e., ventilator) support exceeds capabilities, the need for developing strategies for addressing the challenges associated the large-scale emergency becomes all the more evident. These strategies should focus not only on how to utilize allocated ventilators adequately or use additional ventilators, but also on how to have sufficient staff, space, or equipment. Koonin et al. arguably state: ‘Facilities must have sufficient staff, space, equipment, and supplies to utilize allocated ventilators adequately’²³. Intensive care unit practitioners, hospital administrators, governments, and policymakers must work towards the achievement of these goals. Moreover, Phua et al. argue that:

*‘researchers must address unanswered questions, including the role of repurposed and experimental therapies. Collaboration at the local, regional, national, and international level offers the best chance of survival for the critically ill’*²⁴.

Furthermore, Daugherty *et al.* are right in stating that ‘knowledge of public perspectives and moral points of reference on these issues is critical’²⁵. Not surprisingly, the plans for the allocation of scarce resources in case of future health emergencies should involve the development of frameworks. Daugherty *et al.* provided a ‘framework, built on a basic scoring system with modifications for specific considerations’, that ‘also creates an opportunity for the legal community to review existing laws and liability protections in light of a specific disaster response process’²⁵.

Also, it should be highlighted that encouraging an ongoing and mutually respectful dialogue between all stakeholders should be considered responsibility of the state.

I highlight the role of bioethicists in promoting such a dialogue²⁶. This dialogue should inform the patient prioritization guidelines in case of a medical emergency in order for the principles of consensus and social proof to be met.

Conclusion

Except for such rare situations where there might be an absence of the physician's imputability, physicians cannot 'save the most lives while respecting the legal rights of the patient' without violating the overarching principle 'every human life has equal value'. Arguing to the contrary is a conscious hypocritical attitude, a fiction. Various fictions are found in medical law and ethics. Furthermore, in a public health emergency such as the current COVID-19 crisis, medical law and ethics changes and shifts focus from the patient-centered model towards the public health-centered model. Under these particular circumstances, this fiction becomes striking. As health emergencies can happen anywhere, anytime, the patient prioritization in circumstances of limited resources should be accepted. Medical law and ethics should prominently backtrack from strict commitment to placing paramount emphasis on the value of human life. It is time for medical law and ethics to leave taboo-related hypocritical attitudes and make a historic compromise. To do so, three conditions should be met. First, the principle of subsidiarity. Before the occurrence of a health emergency, all the involved stakeholders should have done their utmost to circumvent or eliminate potential conflict between fundamental bioethical principles, according to the bioethical principle of mutuality. Second, the principle of proportionality. Third, the principle of consensus and social proof. Ongoing mutually respectful dialogue between all the stakeholders (including the public) involved in the conflict of the fundamental bioethical principles should inform the patient prioritization guidelines in case of a medical emergency.

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Availability of Data and Materials

This paper is based on publicly available data and materials. For this paper, I made use of articles published in international journals, to be found on, for example, PubMed.

Competing Interests

The author declares that he has no competing interests.

Author Contribution

Dr. Polychronis Voultzos conceived and designed the study, collected and analyzed the data, and prepared and approved the manuscript.

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